SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Filing at a Glance

Company: Continental American Insurance Company

Product Name: AR Combo App	SERFF Tr Num: CAIC-126148589	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 42359
Sub-TOI: H21.000 Health - Other	Co Tr Num: 153	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Lindsay Morden	Disposition Date: 05/18/2009
	Date Submitted: 05/12/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AR Combo App	Status of Filing in Domicile: Pending
Project Number: 153	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 05/18/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/18/2009
Deemer Date:	Corresponding Filing Tracking Number: 153

Filing Description:

May 12, 2009

RE: CONTINENTAL AMERICAN INSURANCE COMPANY

NAIC: 71730 FEIN: 57-0514130

FORM NUMBERS: See attached list

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

The enclosed application form is being sent to your department for your review and approval. The application will be used with products previously filed and approved by your department. We will not use this application for products that are not approved in your state.

They will be marketed to employees of an employer on a voluntary group basis. Each employee will typically complete the application on a one on one basis, with an agent present.

We would like to be able to customize this application as needed for each group and ask that you consider each section (Critical Illness, Accident, and Mid Med) as variable. This will enable us to delete that specific product section when that product(s) are not being sold to a particular group. Example – If the employer were interested in offering only Accident and Critical insurance to his employees, the application would only contain those two sections.

Thank you for your consideration in this matter. Please contact Lindsay Morden at (888) 730-2244 extension 4335 or by e-mail at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

James J. Hennessy, AIRC, ACP
Assistant Vice President, Compliance

Company and Contact

Filing Contact Information

Lindsay Morden, lmorden@caicworksite.com
2801 Devine Street (803) 461-4335 [Phone]
Columbia, SC 29205

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code:	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	$50.00	05/12/2009	27810053

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
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Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/18/2009	05/18/2009

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Disposition

Disposition Date: 05/18/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	application	Approved-Closed	Yes

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*42359*
Company Tracking Number:	*153*		
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Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Form Schedule

Lead Form Number: CAI1012AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CAI1012AR	Application/ Enrollment Form	application	Initial		50	CAI1012AR.pdf

CAIC
CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail to: PO Box 2086
Fort Mill, SC 29716-2086
(866)-543-0896

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Critical Illness		
Accident		
MidMed		
GAP		

Endorsement:

EFFECTIVE DATE:

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number	Gender	Date of Birth
Street Address	City		State	Zip
Employer	Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth		
		Employee		
Are you actively at work?		☐ **YES** ☐ **NO**		

List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	Gender	Date of Birth	Name	Gender	Date of Birth

Type of Coverage

1

[MIDMED - Plan Selection _____

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family **Cost per pay period: $**_____

☐ New Enrollment ☐ Change

Special Circumstance

Date_____ Reason _____

Section 125 ☐ Yes ☐ No]

2

[GAP -

Current Coverage-

1. Do you participate in the employer's, or another major medical or comprehensive medical insurance coverage? ☐ Yes ☐ No

2. Are any proposed insureds for coverage covered by an Title XIX program (e.g. Medicaid, Medicare, Champus or Tricare)? ☐ Yes ☐ No

Plan Selection _____

☐ *Employee* ☐ *Employee & Spouse* ☐ *Employee & Children* ☐ *Family* ***Cost per pay period: $***_____

☐ New Enrollment ☐ Change

Section 125 ☐ Yes ☐ No

Special Circumstance

Date_____ **Reason** _____

Benefit Plan Options

	BASE BENEFIT			***BUY UP BENEFIT***			
Employer Paid	***Inpatient Benefit***	***Premium***	***Employee Paid***	***Inpatient Benefit***	***Premium***	***Total Coverage***	***Total Premium***

1. Spouse or equivalent, as defined by governing state law
2. Marriage or equivalent, as defined by governing state law
3. Voluntary benefit will only be issued when the required participation is met

3	**[CRITICAL ILLNESS** ☐ Employee ☐ Employee & Spouse Section 125: ☐ Yes ☐ No Employee Face Amount: $_____ ***Employee Cost per pay period:*** $_____ Spouse Face Amount: $_____ ***Spouse Cost per pay period:*** $_____		
		Employee	**Spouse**
1a	Have you used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
1b	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
1c	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
1d	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?]	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
4	**[ACCIDENT** ☐ 24 Hour ☐ Non-Occupational Plan _____ Section 125 ☐ Yes ☐ No ☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family ***Cost per pay period:*** $_____]		

This is Important - Please Read
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: _____

Date of Signature: _____

- **YES, I DO WANT THIS COVERAGE**

• I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.

• All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.

• I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.

• Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

• Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).

• Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty or insurance fraud.

• I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: $ _____

[Member/Employee] Acceptance: _____

Date of Signature:_____

- **No, I decline coverage for myself and/or spouse**

☐ I decline coverage because I am covered under another group policy of medical insurance.

☐ I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.

☐ I decline coverage but I do not have another group policy of medical insurance.

(Member/Employee) Declination: _____

Date of signature: _____

Agent Signature: _____ Date of Signature: _____

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury which was diagnosed or treated by a Doctor prior to the Covered Person's Effective Date of coverage for the Covered Person with consultation, advice or treatment by a Doctor within 6 months prior to the Effective Date of coverage for the Covered Person.

The commissioner may investigate fraudulent insurance acts and persons engaged in the business of insurance

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TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-126148589*	*State:*	*Arkansas*
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Company Tracking Number:	*153*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*AR Combo App*		
Project Name/Number:	*AR Combo App/153*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 05/18/2009
Comments:
Attachment:
CAIC Readability Certificate.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 05/18/2009
Bypass Reason: N/A
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 05/18/2009
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 05/18/2009
Bypass Reason: N/A
Comments:

Continental American
INSURANCE COMPANY

READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following form has the following combined policy, certificate, rider and application readability score as calculated by the Flesch Reading Ease Test**: 50**

Form

CAI1012AR

James J. Hennessy
cn=James J. Hennessy, c=US,
o=VP Compliance, CAIC,
ou=Authorized Consultant,
email=jhennessy@caicworksite.
com
2009.05.12 11:24:53 -04'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance, CAIC

May 12, 2009
Date